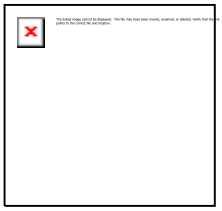

BOARD OF VETERANS' APPEALS
DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON, DC 20420

IN THE APPEAL OF
JOSEPH HARVEY [redacted]

DOCKET NO. 13-10 664) DATE *14 JAN 2016*
) *MDP*
)

On appeal from the
Department of Veterans Affairs Regional Office in St. Petersburg, Florida

THE ISSUES

1. Whether new and material evidence has been received to reopen a claim of entitlement to service connection for nerve damage to the bilateral upper extremities, to include as due to Gulf War illness, and, if so, whether the claim should be granted.

2. Whether new and material evidence has been received to reopen a claim of entitlement to service connection for nerve damage to the bilateral lower extremities, to include as due to Gulf War illness, and, if so, whether the claim should be granted.

3. Whether new and material evidence has been received to reopen a claim of entitlement to service connection for sleep apnea, to include as secondary to the service-connected psychiatric disability and/or as due to Gulf War illness, and, if so, whether the claim should be granted.

4. Whether new and material evidence has been received to reopen a claim of entitlement to service connection for bilateral hearing loss, and, if so, whether the claim should be granted.

5. Whether new and material evidence has been received to reopen a claim of entitlement to service connection for tinnitus, and, if so, whether the claim should be granted.

6. Whether new and material evidence has been received to reopen a claim of entitlement to service connection for headaches, and, if so, whether the claim should be granted.

7. Entitlement to service connection for posttraumatic stress disorder (PTSD).

8. Entitlement to service connection for hypertension, claimed as secondary to the service-connected psychiatric disability.

9. Entitlement to an initial disability rating in excess of 50 percent for depressive disorder not otherwise specified (NOS).

10. Entitlement to an initial compensable disability rating for plantar hyperkeratosis, previously diagnosed as xerosis, of both feet, and psoriasis of the feet.

REPRESENTATION

Appellant represented by: David Anaise, M.D., J.D.

ATTORNEY FOR THE BOARD

T. Sherrard, Counsel

IN THE APPEAL OF [redacted]
JOSEPH HARVEY

INTRODUCTION

The Veteran, who is the Appellant in this case, had active service from June 1988 to June 1992.

This matter comes before the Board of Veterans' Appeals (BVA or Board) from February 2009, February 2013, and April 2013 rating decisions by the above Department of Veterans Affairs (VA) Regional Office (RO).

FINDINGS OF FACT

1. In February 2009, the RO granted entitlement to service connection for depressive disorder; the symptoms of the Veteran's depressive disorder cannot be distinguished from those of his other, currently diagnosed psychiatric disorders; therefore, the grant of entitlement to service connection for depressive disorder constitutes a full grant of the benefits sought on the Veteran's appeal of entitlement to service connection for PTSD.

2. A February 2009 rating decision denied service connection for bilateral hearing loss, and a September 2009 rating decision denied service connection for nerve damage to the bilateral upper and lower extremities, sleep apnea, tinnitus, and headaches; the Veteran did not file timely notices of disagreement, and no evidence or new service records were received within one year of the RO decisions.

3. The evidence associated with the claims file subsequent to the September 2009 rating decision denying service connection for nerve damage to the bilateral upper and lower extremities and sleep apnea is not cumulative, relates to an unestablished fact necessary to substantiate the claims, and raises a reasonable possibility of substantiating the claims for service connection for nerve damage to the bilateral upper and lower extremities and sleep apnea.

4. The evidence associated with the claims file subsequent to the February 2009 and September 2009 rating decisions denying service connection for hearing loss,

tinnitus, and headaches is either redundant or cumulative of previously submitted evidence, does not relate to an unestablished fact, or does not raise a reasonable possibility of substantiating those claims.

5. A medically unexplained chronic multisymptom illness manifested by pain and numbness in the bilateral upper and lower extremities is related to the Veteran's Persian Gulf service.

6. Symptoms of sleep apnea were not continuous or recurrent in service; symptoms of sleep apnea have not been continuous or recurrent since service separation; there is no medical nexus between the current sleep apnea and either active service or a service-connected disability; the current sleep disorder has been attributed to a known diagnosis (sleep apnea), and no provider has found either an undiagnosed illness or a medically unexplained chronic multisymptom illness manifested by sleep apnea.

7. The Veteran's current hypertension is not related to active service or to a service-connected disability.

8. Throughout the initial rating period on appeal, the Veteran's depressive disorder was manifested by occupational and social impairment with deficiencies in most areas.

9. Throughout the initial rating period on appeal, the Veteran's plantar hyperkeratosis and psoriasis of the feet has not required more than topical therapy and affects less than five percent of the total body and exposed areas.

CONCLUSIONS OF LAW

1. There remain no allegations of errors of fact or law for appellate consideration regarding the claim for service connection for PTSD. 38 U.S.C.A. § 7105(d)(5) (West 2014).

2. The February 2009 and September 2009 rating decisions, which denied service connection for nerve damage to the bilateral upper and lower extremities, sleep apnea, bilateral hearing loss, tinnitus, and headaches became final. 38 U.S.C.A. § 7105 (West 2014); 38 C.F.R. §§ 20.302, 20.1103 (2015).

3. The evidence relating to the nerve damage to the bilateral upper and lower extremity and sleep apnea claims received subsequent to the September 2009 rating decision is new and material, and the claims for service connection for nerve damage to the bilateral upper and lower extremities and sleep apnea are reopened. 38 U.S.C.A. § 5108 (West 2014); 38 C.F.R. § 3.156 (2015).

4. The evidence received subsequent to the February 2009 and September 2009 rating decisions is not new and material to reopen the claims of entitlement to service connection for bilateral hearing loss, tinnitus, and headaches. 38 U.S.C.A. § 5108 (West 2014); 38 C.F.R. § 3.156 (2015).

5. The criteria for service connection for a medically unexplained chronic multisymptom illness manifested by pain and numbness of the bilateral upper extremities as a result of exposure to environmental hazards during Gulf War service, claimed as nerve damage, are met. 38 U.S.C.A. §§ 101, 1101, 1110, 1117, 1131, 5103(a), 5130A, 5107 (West 2014); 38 C.F.R. § 3.102, 3.159, 3.303, 3.304, 3.317 (2015).

6. The criteria for service connection for a medically unexplained chronic multisymptom illness manifested by pain and numbness of the bilateral lower extremities as a result of exposure to environmental hazards during Gulf War service, claimed as nerve damage, are met. 38 U.S.C.A. §§ 101, 1101, 1110, 1117, 1131, 5103(a), 5130A, 5107 (West 2014); 38 C.F.R. § 3.102, 3.159, 3.303, 3.304, 3.317 (2015).

7. The criteria for service connection for sleep apnea, to include as due to undiagnosed illness or other qualifying chronic disability, pursuant to 38 U.S.C.A. §1117, have not been met. 38 U.S.C.A. §§ 101, 1101, 1110, 1117, 1131, 5103(a), 5130A, 5107 (West 2014); 38 C.F.R. § 3.102, 3.159, 3.303, 3.304, 3.317 (2015).

8. The criteria for service connection for hypertension have not been met. 38 U.S.C.A. §§ 101, 1101, 1110, 1112, 1113, 1131, 5103(a), 5103A, 5107 (West 2014); 38 C.F.R. §§ 3.102, 3.159, 3.303, 3.304, 3.307, 3.309, 3.310 (2015).

9. Resolving reasonable doubt in the Veteran's favor, the criteria for a 70 percent disability rating for depressive disorder have been met for the entire initial rating period on appeal. 38 U.S.C.A. §§ 1155, 5103(a), 5103A, 5107 (West 2014); 38 C.F.R. §§ 3.102, 3.159, 4.1, 4.2, 4.3, 4.7, 4.10, 4.130, Diagnostic Code (DC) 9434 (2015).

10. The criteria for an initial compensable disability rating for plantar hyperkeratosis and psoriasis of the feet have not been met for any period. 38 U.S.C.A. §§ 1155, 5103(a), 5103A, 5107 (West 2014); 38 C.F.R. §§ 3.102, 3.159, 4.1, 4.2, 4.3, 4.7, 4.10, 4.118, Diagnostic Code 7899-7824 (2015).

REASONS AND BASES FOR FINDINGS AND CONCLUSIONS

Dismissal of PTSD Claim

Under 38 U.S.C. § 7105(d)(5), the Board may dismiss any appeal which fails to allege specific error of fact or law in the determination being appealed.

In a February 2009 rating decision, service connection was granted for depressive disorder. The Board finds that the medical evidence of record indicates that the Veteran's psychiatric symptoms cannot be differentiated between the service-connected depressive disorder and non-service-connected PTSD. VA treatment notes indicate he has been variously diagnosed with both PTSD and depression, and that the same or similar symptoms – such as depressed mood, panic, social isolation, and anxiety – have been attributed to both diagnoses.

Controlling law precludes the Board from attributing the Veteran's psychiatric symptoms to a non-service-connected disability rather than his service-connected

disability in the absence of medical evidence which does so. *See Mittleider v. West*, 11 Vet. App. 181, 182 (1998); *see also* 38 C.F.R. §§ 4.14 ("The evaluation of the same disability under various diagnoses is to be avoided.") and 4.130 (setting forth schedule of ratings for mental disorders which contains criteria that apply regardless of the particular diagnosis given to the psychiatric symptoms). Without there being any clear medical opinion delineating the symptoms attributable to each diagnosis, and resolving all doubt in the Veteran's favor, the Board will attribute all of his psychiatric symptoms to his service-connected depressive disorder.

Because the Board finds that all of the Veteran's psychiatric symptomatology must be attributed to his service-connected depressive disorder, the grant of entitlement to service connection for depressive disorder constituted a grant in full of the benefit the Veteran is seeking with respect to entitlement to service connection for PTSD. Hence, there remain no allegations of errors of fact or law for appellate consideration regarding the claim for service connection for PTSD, the Board does not have jurisdiction to review it, and it is dismissed.

New and Material Evidence for Nerve Damage to the Upper and Lower Extremities, Sleep Apnea, Hearing Loss, Tinnitus, and Headache Claims

In July 2008 and January 2009, the Veteran filed initial claims for service connection for nerve damage to the extremities, sleep apnea, hearing loss, tinnitus, and headaches. The hearing loss claim was denied in a February 2009 rating decision, while the remainder of the claims was denied in a September 2009 rating decision. The RO found that there was no evidence of a nexus between the current claimed disabilities and active service. The Veteran did not file timely notices of disagreement (NOD), and no evidence or new service records were received within one year of the RO decisions. 38 C.F.R. § 3.156(b) and 3.156(c) (2015). Consequently, the February 2009 and September 2009 rating decisions became final. *See* 38 U.S.C.A. § 7105; 38 C.F.R. §§ 20.302, 20.1103.

In April 2011, the Veteran filed a request to reopen his claims for service connection for the above disabilities. In the April 2013 rating decision on appeal, the RO denied reopening of the claims for service connection for nerve damage to

the extremities, hearing loss, tinnitus, and headaches, finding that no new and material evidence had been received. The RO reopened the sleep apnea claim and denied it on the merits.

Based on the procedural history outlined above, the issue for consideration with respect to the Veteran's claims is whether new and material evidence has been received to reopen the claims of entitlement to service connection for nerve damage to the extremities, sleep apnea, hearing loss, tinnitus, and headaches.

Notwithstanding the determination of the RO regarding reopening or not reopening the claims, the preliminary question of whether a previously denied claim should be reopened is a jurisdictional matter that must be addressed before the Board may consider the underlying claim on its merits. *Barnett v. Brown*, 8 Vet. App. 1, 4, (1995), *aff'd*, *Barnett v. Brown*, 83 F.3d 130 (Fed. Cir. 1996).

"New" evidence is defined as evidence not previously received by agency decision-makers. "Material" evidence means existing evidence that, by itself or when considered with previous evidence of record, relates to an unestablished fact necessary to substantiate the claim. New and material evidence can be neither cumulative nor redundant of the evidence of record at the time of the last prior final denial of the claim sought to be reopened, and must raise a reasonable possibility of substantiating the claim. 38 C.F.R. § 3.156(a) (2015).

In order for evidence to be sufficient to reopen a previously disallowed claim, it must be both new and material. If the evidence is new, but not material, the inquiry ends and the claim cannot be reopened. *See Smith v. West*, 12 Vet. App. 312, 314 (1999). If it is determined that new and material evidence has been received, the claim must be reopened. The VA may then proceed to evaluate the merits of the claim on the basis of all evidence of record, but only after ensuring that the duty to assist the veteran in developing the facts necessary for his claim has been satisfied. *See Elkins v. West*, 12 Vet. App. 209 (1999), *but see* 38 U.S.C.A. § 5103A (eliminating the previous requirement of a well-grounded claim).

The threshold for determining whether new and material evidence raises a reasonable possibility of substantiating a claim is "low." *See Shade v. Shinseki*, 24 Vet. App. 110, 117 (2010). Furthermore, in determining whether this low threshold is met, VA should not limit its consideration to whether the newly received evidence relates specifically to the reason why the claim was last denied, but instead should ask whether the evidence could reasonably substantiate the claim were the claim to be reopened, either by triggering the VA Secretary's duty to assist or through consideration of an alternative theory of entitlement. *Id.* at 118. The evidence received to reopen a claim is presumed to be true for the purpose of determining whether new and material evidence has been received. *Duran v. Brown*, 7 Vet. App. 216, 220 (1994); *Justus v. Principi*, 3 Vet. App. 510, 513 (1992).

Since the last final September 2009 denial of the nerve damage and sleep apnea claims, new and material evidence has been received. Namely, a March 2013 VA treatment note suggests that the nerve damage to the extremities might be a result of the Veteran's Gulf War service. Further, the Veteran submitted an article suggesting a correlation between sleep apnea and psychiatric disabilities. Therefore, the Board finds that the evidence added to the record since the previous September 2009 denial constitutes new and material evidence, and that the criteria under 38 C.F.R. § 3.156(a) have been satisfied with regard to the nerve damage and sleep apnea claims; therefore, the claims for service connection for nerve damage to the bilateral upper and lower extremities and sleep apnea are reopened.

Next, with regard to the hearing loss, tinnitus, and headache claims, the evidence of record at the time of the last final February and September 2009 rating decisions denying service connection included service treatment records, post-service VA and private treatment records, the Veteran's statements, and VA examination reports.

Although in-service acoustic trauma and possible exposure to toxins were conceded in light of the Veteran's combat service in Saudi Arabia, service treatment records did not show any symptoms, reports, findings, diagnosis, or treatment for hearing loss, tinnitus, or headaches.

Following separation from service, the first report or complaint of hearing loss and tinnitus was in July 2008 and January 2009, respectively, when the Veteran filed his claims for service connection 16 years after service separation. A January 2009 VA examiner opined that the Veteran's current hearing loss and tinnitus were not caused by or related to his military noise exposure. The examiner noted that word recognition abilities were worse than expected given his normal thresholds demonstrated on the audiogram, and, therefore, the reduced word recognition scores were questionable for rating purposes. Moreover, the VA examiner noted that hearing thresholds were within normal limits both currently and at the time of separation from service.

The first post-service report of headaches was in 2006, when the Veteran suffered a transient ischemic attack (TIA) that was differentially diagnosed as a complicated migraine. VA treatment notes from 2008 indicate that the Veteran reported occasional headaches, and told a VA clinician that he stopped taking Requip (medication for his restless leg syndrome) because it was causing him to have headaches.

Finally, an August 2009 VA examiner opined that the claimed headaches, diagnosed as jaw clincher and/or tension type headaches, were not caused by environmental exposure in the Persian Gulf, and that there were no undiagnosed conditions manifesting headaches. The VA examiner based this opinion in part on his personal observation of the Veteran clenching his jaw during the two-and-a-half hour examination and on his interview and examination of the Veteran.

Based on this evidence, in the February and September 2009 rating decisions, the RO denied the claims for service connection for hearing loss, tinnitus, and headaches, finding no evidence of a medical nexus between the claimed disabilities and active service. Moreover, the RO found that the evidence demonstrated that headaches were attributed to a known diagnosis (jaw clincher or tension headaches), and there was no undiagnosed illness or a medically unexplained chronic multisymptom illness manifested by headaches.

Evidence added to the record since the time of the last final denial in February and September 2009 includes updated post-service VA and private treatment records, statements of the Veteran, and new VA examination reports. However, none of the updated treatment records or VA opinions suggests a nexus between the claimed disabilities and active service. Indeed, the April 2013 VA audiological examiner opined that the current hearing loss and tinnitus were less likely as not due to military noise exposure, but, rather, were more likely impacted by civilian noise exposure, presbycusis, and/or some other etiology. In addition, at an April 2013 headache examination, the Veteran stated that his headaches were no longer a problem, and that he no longer wished to claim service connection for headaches. Moreover, the statements of the Veteran are redundant.

The evidence added to the record since the previous February and September 2009 denial of the claims for service connection for hearing loss, tinnitus, and headaches does not constitute new and material evidence. Although some of the evidence is new, in that it was not associated with the claims file prior to the last final denial in February and September 2009, for the reasons set forth above, such evidence is not material because it is redundant or cumulative of previously submitted evidence, does not relate to an unestablished fact, and does not raise a reasonable possibility of substantiating the service connection claim. Indeed, as explained above, the new evidence weighs against a grant of the claimed disabilities.

As noted above, the statements of the Veteran on the matter are redundant and cumulative because they just reiterate previously considered assertions. Moreover, the medical evidence continues to reveal that there is no connection between the current claimed disabilities and active service, so such evidence does not relate to an unestablished fact. All the evidence together does not raise a reasonable possibility of substantiating the claims. Therefore, the Board finds that the new and material criteria under 38 C.F.R. § 3.156(a) have not been satisfied, and the claims of entitlement to service connection for hearing loss, tinnitus, and headaches cannot be reopened.

Service Connection Laws and Regulations

Service connection may be granted for a disability resulting from disease or injury incurred in or aggravated by active military, naval, or air service. 38 U.S.C.A. §§ 1110, 1131; 38 C.F.R. § 3.303(a). Establishing service connection generally requires (1) medical evidence of a current disability; (2) medical or, in certain circumstances, lay evidence of in-service incurrence or aggravation of a disease or injury; and (3) medical evidence of a nexus between the claimed in-service disease or injury and the present disability. *Shedden v. Principi*, 381 F.3d 1163, 1167 (Fed. Cir. 2004). The United States Court of Appeals for Veterans Claims (Court) has held that "Congress specifically limits entitlement for service-connected disease or injury to cases where such incidents have resulted in a disability. In the absence of proof of a present disability there can be no valid claim." *Brammer v. Derwinski*, 3 Vet. App. 223, 225 (1992); *see also Rabideau v. Derwinski*, 2 Vet. App. 141, 143-44 (1992).

Where a veteran who served for ninety days or more during a period of war (or during peacetime service after December 31, 1946) develops certain chronic diseases, such as hypertension, to a degree of 10 percent or more within one year from separation from service, such diseases may be presumed to have been incurred in service even though there is no evidence of such disease during the period of service. This presumption is rebuttable by affirmative evidence to the contrary. *See* 38 U.S.C.A. §§ 1101, 1112, 1113, 1137 (West 2014); 38 C.F.R. §§ 3.307, 3.309 (2015).

In this case, the evidence of record demonstrates a current diagnosis of hypertension. Where the veteran asserts entitlement to service connection for a chronic disease but there is insufficient evidence of a diagnosis in service, service connection may be established under 38 C.F.R. § 3.303(b) by demonstrating a continuity of symptomatology since service or diagnosis within the presumptive period after service, but only if the chronic disease is listed under 38 C.F.R. § 3.309(a). *Walker v. Shinseki*, 708 F.3d 1331, 1338-39 (Fed. Cir. 2013); 38 C.F.R. § 3.307 (service connection authorized for chronic diseases diagnosed within the presumptive period). However, in this case, the Veteran has not contended that hypertension began during active service. Moreover, for the reasons set forth

below, the Veteran was not diagnosed with hypertension within one year of separation from service, nor has there been continuity of symptomatology.

With specific regard to continuity of symptomatology, for the showing of chronic disease in service, there is required a combination of manifestations sufficient to identify the disease entity, and sufficient observation to establish chronicity at the time. With chronic disease as such in service, subsequent manifestations of the same chronic disease at any later date, however remote, are service-connected, unless clearly attributable to intercurrent causes. If a condition, such as hypertension, noted during service is not shown to be chronic, then generally, a showing of continuity of symptoms after service is required for service connection. 38 C.F.R. § 3.303(b).

Service connection may also be granted for any disease diagnosed after discharge, when all the evidence, including that pertinent to service, establishes that the disease was incurred in service. 38 C.F.R. § 3.303(d).

In addition, service connection may be granted for a disability that is proximately due to or the result of a service-connected disability. *See* 38 C.F.R. § 3.310(a). When service connection is thus established for a secondary condition, the secondary condition shall be considered a part of the original condition. *See* 38 C.F.R. § 3.310(a); *Harder v. Brown*, 5 Vet. App. 183, 187 (1993). The controlling regulation has been interpreted to permit a grant of service connection not only for disability caused by a service-connected disability, but for the degree of disability resulting from aggravation of a non-service-connected disability by a service-connected disability. *See Allen v. Brown*, 7 Vet. App. 439, 448 (1995). "Aggravation" is defined for this purpose as a chronic, permanent worsening of the underlying condition, beyond its natural progression, versus a temporary flare-up of symptoms. *Id.*

To prevail on the theory of secondary service causation, generally, the record must show (1) medical evidence of a current disability, (2) a service-connected disability, and (3) medical nexus evidence establishing a connection between the current

disability and the service-connected disability. *Wallin v. West*, 11 Vet. App. 509, 512 (1998); *Reiber v. Brown*, 7 Vet. App. 513, 516-17 (1995).

Further, special service connection rules exist for Persian Gulf Veterans. 38 U.S.C.A. § 1117; 38 C.F.R. § 3.317. The Southwest Asia Theater of operations includes Iraq, Kuwait, Saudi Arabia, the neutral zone between Iraq and Saudi Arabia, Bahrain, Qatar, the United Arab Emirates, Oman, the Gulf of Aden, the Gulf of Oman, the Persian Gulf, the Arabian Sea, the Red Sea, and the airspace above these locations. 38 C.F.R. § 3.317€(2).

Under 38 C.F.R. § 3.317, service connection may be warranted for a Persian Gulf Veteran who exhibits objective indications of a qualifying chronic disability that became manifest during active military, naval or air service in the Southwest Asia Theater of operations during the Persian Gulf War. For disability due to undiagnosed illness and medically unexplained chronic multisymptom illness, the disability must have been manifest either during active military service in the Southwest Asia Theater of operations or to a degree of 10 percent or more not later than December 31, 2016. 38 C.F.R. § 3.317(a)(1).

For purposes of 38 C.F.R. § 3.317, there are three types of qualifying chronic disabilities: (1) an undiagnosed illness; (2) a medically unexplained chronic multisymptom illness; and (3) a diagnosed illness that the Secretary determines warrants a presumption of service connection. 38 U.S.C.A. § 1117(d).

An undiagnosed illness is defined as a condition that by history, physical examination and laboratory tests cannot be attributed to a known clinical diagnosis. In the case of claims based on undiagnosed illness under 38 U.S.C.A. § 1117; 38 C.F.R. § 3.317, unlike those for "direct service connection," there is no requirement that there be competent evidence of a nexus between the claimed illness and service. *Gutierrez v. Principi*, 19 Vet. App. 1, 8-9 (2004). Further, lay persons are competent to report objective signs of illness. *Id.* To determine whether the undiagnosed illness is manifested to a degree of 10 percent or more, the condition must be rated by analogy to a disease or injury in which the functions affected,

anatomical location or symptomatology are similar. *See* 38 C.F.R. § 3.317(a)(5); *see also Stankevich v. Nicholson*, 19 Vet. App. 470 (2006).

A medically unexplained chronic multisymptom illness is one defined by a cluster of signs or symptoms and specifically includes chronic fatigue syndrome, fibromyalgia, and functional gastrointestinal disorders (excluding structural gastrointestinal diseases), as well as any other illness that the Secretary determines meets the criteria in paragraph (a)(2)(ii) of this section for a medically unexplained chronic multisymptom illness. A "medically unexplained chronic multisymptom illness" means a diagnosed illness without conclusive pathophysiology or etiology that is characterized by overlapping symptoms and signs and has features such as fatigue, pain, disability out of proportion to physical findings, and inconsistent demonstration of laboratory abnormalities. Chronic multisymptom illnesses of partially understood etiology and pathophysiology will not be considered medically unexplained. 38 C.F.R. § 3.317(a)(2)(ii).

"Objective indications of chronic disability" include both "signs," in the medical sense of objective evidence perceptible to an examining physician, and other, non-medical indicators that are capable of independent verification. 38 C.F.R. § 3.317(a)(3). Signs or symptoms that may be manifestations of undiagnosed illness or medically unexplained chronic multisymptom illness include, but are not limited to, the following: (1) fatigue; (2) signs or symptoms involving skin; (3) headache; (4) muscle pain; (5) joint pain; (6) neurologic signs or symptoms; (7) neuropsychological signs or symptoms; (8) signs or symptoms involving the respiratory system (upper or lower); (9) sleep disturbances; and other symptoms not applicable to this claim. 38 C.F.R. § 3.317(b).

For purposes of section 3.317, disabilities that have existed for six months or more and disabilities that exhibit intermittent episodes of improvement and worsening over a six-month period will be considered chronic. The six-month period of chronicity will be measured from the earliest date on which the pertinent evidence establishes that the signs or symptoms of the disability first became manifest. 38 C.F.R. § 3.317(a)(4).

Where the evidence does not warrant presumptive service connection, the United States Court of Appeals for the Federal Circuit (Federal Circuit) has determined that a Veteran is not precluded from establishing service connection with proof of direction causation. *Combee v. Brown*, 34 F.3d 1039 (Fed. Cir. 1994).

In rendering a decision on appeal, the Board must analyze the credibility and probative value of the evidence, account for the evidence which it finds to be persuasive or unpersuasive, and provide the reasons for its rejection of any material evidence favorable to the claimant. *See Gabrielson v. Brown*, 7 Vet. App. 36, 39-40 (1994); *Gilbert v. Derwinski*, 1 Vet. App. 49, 57 (1990). Competency of evidence differs from weight and credibility. Competency is a legal concept determining whether testimony may be heard and considered by the trier of fact, while credibility is a factual determination going to the probative value of the evidence to be made after the evidence has been admitted. *Rucker v. Brown*, 10 Vet. App. 67, 74 (1997); *Layno v. Brown*, 6 Vet. App. 465, 469 (1994); *see also Cartright v. Derwinski*, 2 Vet. App. 24, 25 (1991) ("although interest may affect the credibility of testimony, it does not affect competency to testify").

Lay testimony is competent when it regards the readily observable features or symptoms of injury or illness and "may provide sufficient support for a claim of service connection." *See Layno*, 6 Vet. App. At 469; 38 C.F.R. § 3.159(a)(2). The Court has emphasized that when a condition may be diagnosed by its unique and readily identifiable features, the presence of the disorder is not a determination "medical in nature" and is capable of lay observation. In such cases, the Board is within its province to weigh that testimony and to make a credibility determination as to whether that evidence supports a finding of service incurrence and continuity of symptomatology sufficient to establish service connection. *See Barr v. Nicholson*, 21 Vet. App. 303 (2007); *Davidson v. Shinseki*, 581 F.3d 1313 (Fed. Cir. Sept. 14, 2009). Lay statements may serve to support a claim for service connection by supporting the occurrence of lay-observable events or the presence of disability or symptoms of disability subject to lay observation. *See Jandreau v. Nicholson*, 492 F.3d 1372 (Fed. Cir. 2007); *Buchanan v. Nicholson*, 451 F.3d 1331, 1336 (Fed. Cir. 2006) (addressing lay evidence as potentially competent to support

presence of disability even where not corroborated by contemporaneous medical evidence).

Generally, the degree of probative value which may be attributed to a medical opinion issued by a VA or private treatment provider takes into account such factors as its thoroughness and degree of detail, and whether there was review of a veteran's claims file. *See Prejean v. West*, 13 Vet. App. 444, 448-9 (2000). Also significant is whether the examining medical provider had a sufficiently clear and well-reasoned rationale, as well as a basis in objective supporting clinical data. *See Bloom v. West*, 12 Vet. App. 185, 187 (1999); *Hernandez-Toyens v. West*, 11 Vet. App. 379, 382 (1998); *see also Claiborne v. Nicholson*, 19 Vet. App. 181, 186 (2005) (rejecting medical opinions that did not indicate whether the physicians actually examined the veteran, did not provide the extent of any examination, and did not provide any supporting clinical data). The Court has held that a bare conclusion, even one reached by a health care professional, is not probative without a factual predicate in the record. *Miller v. West*, 11 Vet. App. 345, 348 (1998).

A significant factor to be considered for any opinion is the accuracy of the factual predicate, regardless of whether the information supporting the opinion is obtained by review of medical records or lay reports of injury, symptoms and/or treatment. *See Harris v. West*, 203 F.3d 1347, 1350-51 (Fed. Cir. 2000) (examiner opinion based on accurate lay history deemed competent medical evidence in support of the claim); *Kowalski v. Nicholson*, 19 Vet. App. 171, 177 (2005) (holding that a medical opinion cannot be disregarded solely on the rationale that the medical opinion was based on history given by the veteran); *Reonal v. Brown*, 5 Vet. App. 458, 461 (1993) (holding that the Board may reject a medical opinion based on an inaccurate factual basis).

When all the evidence is assembled, VA is responsible for determining whether the evidence supports the claim or is in relative equipoise, with a veteran prevailing in either event, or whether a preponderance of the evidence is against a claim, in which case, the claim is denied. 38 U.S.C.A. § 5107(b); 38 C.F.R. § 3.102.

The Board has reviewed all the evidence in the Veteran's claims file. Although the Board has an obligation to provide adequate reasons and bases supporting this decision, there is no requirement that the evidence submitted by a veteran or obtained on his behalf be discussed in detail. Rather, the Board's analysis below will focus specifically on what evidence is needed to substantiate the claim and what the evidence in the claims file shows, or fails to show, with respect to the claim. *See Gonzales v. West*, 218 F.3d 1378, 1380-81 (Fed. Cir. 2000); *Timberlake v. Gober*, 14 Vet. App. 122, 128-30 (2000).

Service Connection for Nerve Damage
to the Bilateral Upper and Lower Extremities

The Veteran contends that he has nerve damage to the bilateral upper and lower extremities, manifested by severe pain, caused by Gulf War illness.

Private treatment records from July 1999 indicate that the Veteran reported severe aches in his arms and legs that had been present for eight years, placing its onset during active service. The doctor assessed profound weakness with associated arthralgias and myalgias and prominent distal extremity pains of uncertain etiology. The doctor further noted his concern about the Veteran's Desert Storm exposure to toxins. An EMG study indicated moderate to severe carpal tunnel syndrome bilaterally.

In August 1999, one month later, the same doctor assessed possible fibromyalgia with a generalized ache and pain syndrome.

In May 2006, an EMG study revealed left median, left ulnar, right peroneal, and right tibial neuropathies. The interpreter of the study noted that the pattern of nerve injury suggested multi-focal neuropathy that may suggest a hereditary neuropathy with propensity for pressure-induced palsies. In addition, the interpreter noted early changes to the right median nerve.

In August 2006, the Veteran was diagnosed with leg pain, polyneuropathy, and periodic limb movement disorder (or restless leg syndrome).

In October 2008, he continued to report unbearable chronic pain from the elbows down and the knees down ever since he came back from the Persian Gulf. He underwent a Gulf War examination the following month in November 2008, at which he reported that he began experiencing the pain in his arms and legs in approximately April 1992 while stationed in Virginia two months prior to his discharge from service.

He was afforded a VA examination in August 2009. That examiner noted that bilateral carpal tunnel syndrome had been confirmed by EMG study, but also noted that *the distribution of the Veteran's pain was not a pattern consistent with carpal tunnel syndrome*. The VA examiner opined that the bilateral carpal tunnel syndrome was not caused by environmental exposure in the Persian Gulf and that there was no undiagnosed illness. However, he also stated that the pain sensation experienced as early as 1999 was "over-interpreted by the brain as a result of major depressive disorder." This somewhat confusing statement with no rationale provided suggests that the arm pain experienced by the Veteran is caused or aggravated by his service-connected depressive disorder. The examiner also suggests that the arm pain is not caused by the carpal tunnel syndrome, but, rather, has a separate and distinct etiology.

In March 2013, VA treatment notes show that the Veteran continued to complain of pain in his arms and legs. The VA clinician noted that he had been taking medication for restless leg syndrome but reported no change in his symptoms. The clinician was unable to make a diagnosis with regard to the extremity pain, and assessed *small fiber neuropathy versus Gulf War syndrome versus possible restless leg syndrome*. The clinician suggested the Veteran see a neurologist for further work-up.

While a VA examination and opinion was obtained in April 2013 to address the nerve damage claim, the examiner did not explain the confusion reflected in the treatment records and prior VA examination regarding the appropriate diagnosis,

nor did the examiner address the prior 2009 VA examiner's statement regarding a possible link between the Veteran's arm pain and his service-connected depressive disorder.

In sum, the Veteran's treating and examining physicians have not been able to adequately explain his bilateral upper and lower extremity symptoms with a clear diagnosis or etiology. As explained above, VA regulations provide for presumptive service connection for Persian Gulf veterans for medically unexplained chronic multisymptom illnesses without conclusive pathophysiology or etiology. Symptoms of such illnesses include, but are not limited to, muscle pain, neurological signs or symptoms, and neuropsychological signs or symptoms, all of which are present in this case. 38 C.F.R. § 3.317.

Obtaining an additional medical opinion in this case is unlikely to provide any clarity regarding the Veteran's diagnosis or the etiology of his arm and leg symptoms. Resolving reasonable doubt in the Veteran's favor, the Board finds that service connection for a medically unexplained chronic multisymptom illness manifested by pain and numbness of the bilateral upper and lower extremities as a result of exposure to environmental hazards during Gulf War service, claimed as nerve damage, is warranted.

Service Connection for Sleep Apnea

The Veteran contends that his current sleep apnea is related to active service. Specifically, he avers that it is a symptom of Gulf War illness. In the alternative, he contends that his sleep apnea is secondary to his service-connected psychiatric disability.

After a review of all the evidence of record, lay and medical, the Board finds that the preponderance of the evidence demonstrates that there was no event, injury, or disease manifesting sleep apnea during active service, and that symptoms of sleep apnea were not recurrent in service.

The Veteran's service treatment records, including the May 1988 service enlistment examination report and May 1992 separation examination report, are silent as to any findings, complaints, symptoms, or diagnoses of sleep apnea.

The Board next finds that the preponderance of the evidence demonstrates that symptoms of sleep apnea have not been recurrent since separation from active service in June 1992. As noted above, the May 1992 separation examination report is negative for any complaints or diagnosis of sleep apnea.

Following separation from service in June 1992, the evidence of record does not show any complaints, diagnosis, or treatment for sleep apnea until October 2006, when the Veteran underwent a sleep study and was diagnosed with sleep apnea.

The absence of post-service complaints, findings, diagnosis, or treatment for sleep apnea for 14 years after service separation is one factor that tends to weigh against a finding of recurrent symptoms of sleep apnea after service separation. *See Buchanan*, 451 F.3d 1336 (the lack of contemporaneous medical records is one fact the Board can consider and weigh against the other evidence, although the lack of such medical records does not, in and of itself, render the lay evidence not credible).

Additional evidence demonstrating that symptoms of sleep apnea have not been recurrent since service separation includes the statements of the Veteran, in that he has not contended that his sleep apnea symptoms began during active service or contested the fact that he was not diagnosed with sleep apnea until 2006. The Veteran's statements provide highly probative evidence against a finding that he has had recurrent sleep apnea symptoms since active service.

The Board acknowledges that symptoms, not treatment, are the essence of any evidence of continuity of symptomatology (*Savage v. Gober*, 10 Vet. App. 488, 496 (1997)); however, here, the Veteran filed a claim for service connection in July 2008 for multiple disabilities, but did not mention sleep apnea symptoms at that time. This suggests to the Board that there was no pertinent symptomatology of sleep apnea at that time. While inaction regarding filing a claim is not necessarily indicative of the absence of symptomatology, where, as here, a veteran takes action

regarding other claims, it becomes reasonable to expect that the Veteran is presenting all issues for which he is experiencing symptoms that he believes are related to service. In other words, the Veteran demonstrated that he understood the procedure for filing a claim for VA disability compensation, and he followed that procedure in other instances where he believed he was entitled to those benefits. In such circumstances, it is more reasonable to expect a complete reporting than for certain symptomatology to be omitted. Thus, the Veteran's inaction regarding a claim for sleep apnea, when viewed in the context of his action regarding other claims for compensation, may reasonably be interpreted as indicative of the Veteran's belief that he did not incur his current sleep apnea in service, or the lack of sleep apnea symptomatology at the time he filed the claim, or both.

To the extent that the Veteran's assertions made in the context of the current disability claim can be interpreted as a contention of recurrent sleep apnea symptoms since service, the Board finds that, while the Veteran is competent to report the onset of symptoms of sleep apnea, these more recent assertions are outweighed by the other, more contemporaneous, lay and medical evidence of record, both in service and after service, and are not reliable. *See Charles v. Principi*, 16 Vet. App. 370 (2002). The Board finds that the Veteran's assertions of recurrent symptoms of sleep apnea after service are not accurate because they are outweighed by other evidence of record that includes the more contemporaneous service treatment records, including the May 1992 separation examination report, which are negative for any signs, symptoms, complaints, treatment, or diagnoses of sleep apnea; the lack of any contention by the Veteran that his sleep apnea symptoms began during active service; the lack of any documentation of reports or treatment for sleep apnea until 2006, 14 years after service separation; and the claim for service connection in July 2008 for multiple disabilities with no mention of sleep apnea symptoms.

As such, the Board does not find that the evidence sufficiently supports recurrent symptomatology of sleep apnea since service, so as to warrant a finding of a nexus between the current sleep apnea and active service.

The Board acknowledges the Veteran's belief that his current sleep apnea is related to active service, to a Gulf War illness, or to his service-connected psychiatric disability. However, his statements alone do not establish a medical nexus. Indeed, while the Veteran is competent to provide evidence regarding matters that can be perceived by the senses, he is not shown to be competent to render medical opinions on questions of etiology. *See Jandreau*; *see also Barr*, 21 Vet. App. 303 (lay testimony is competent to establish the presence of observable symptomatology). As such, as a lay person, he is without the appropriate medical training and expertise to offer an opinion on a medical matter, including the diagnosis, etiology, or causation of a specific disability. The question of diagnosis and causation, in this case, involves complex medical issues that the Veteran is not competent to address. *Jandreau*.

Moreover, the Board finds that no competent medical opinions are of record which support a relationship between the Veteran's current sleep apnea and either active service or a service-connected disability, nor is there any other indication in the medical evidence of record that there is a relationship between the current claimed disorders and either active service or a service-connected disability.

The Veteran was afforded a VA examination in August 2009. The examiner noted the diagnosis of obstructive sleep apnea in 2006 and opined that the current sleep apnea was not caused by or a result of active service, noting that review of service treatment records did not reveal sleep apnea to have been suggested by symptoms reported in the military.

In addition, a VA opinion was obtained in April 2013. The VA examiner reiterated the previous VA examiner's opinion that sleep apnea was not directly related to service, noting that the onset of sleep apnea was in 2006, many years after service separation. Moreover, the examiner opined that the Veteran's current sleep apnea is not proximately due to a result of the service-connected psychiatric disability, citing to a review of medical literature. The examiner further noted that the major cause of sleep apnea is weight gain, noting that the Veteran entered active service weighing 155 pounds, weighed 175 pounds in May 1992, and 255 pounds in March 2013.

In sum, the weight of the competent evidence demonstrates that there is no relationship between the Veteran's claimed sleep apnea and either active service or a service-connected disability. There are no contrary opinions of record.

Finally, the weight of the evidence demonstrates that he has not been diagnosed with a qualifying chronic disability under 38 C.F.R. § 3.317. Namely, the preponderance of the medical evidence demonstrates that the Veteran does not have any chronic disability patterns of an undiagnosed illness, nor does he have a medically unexplained chronic multisymptom illness manifested by sleep apnea. Indeed, the overwhelming weight of the evidence shows that the claimed condition of sleep apnea is diagnosable.

In sum, the Veteran has been diagnosed with a known disorder – sleep apnea. This known diagnosis renders inapplicable the special service connection rules for Persian Gulf Veterans. Moreover, at no point has the Veteran's sleep apnea been deemed a symptom of a medically unexplained chronic illness such as chronic fatigue syndrome, fibromyalgia, or any functional gastrointestinal disorder.

For the foregoing reasons, the presumptive service connection regulations pertaining to Persian Gulf War veterans are inapplicable to this case. 38 U.S.C.A. § 1117; 38 C.F.R. § 3.317.

The Board acknowledges the copy of a Board decision for another veteran granting service connection for sleep apnea as secondary to that veteran's service-connected PTSD. However, in that case, a private psychologist had opined that the veteran's sleep apnea was aggravated by his PTSD, submitting several journal articles supporting her opinion. Another private physician had also provided a favorable nexus opinion between sleep apnea and PTSD, citing to medical literature. Despite a negative opinion based on medical literature provided by a VA examiner, the Board found, in that case, that the medical evidence was at least in equipoise on the question of a medical nexus, and resolved reasonable doubt in favor of the veteran in granting the claim.

By contrast, in this case, there have been no favorable medical opinions supporting a medical nexus between the Veteran's service-connected psychiatric disability and his current sleep apnea. Therefore, in this case, unlike the one submitted by the Veteran, the medical evidence is not in equipoise. Indeed, the weight of the medical evidence is against the Veteran's claim. Moreover, the Board is not bound by its prior decisions.

The Board also acknowledges the article submitted by the Veteran in December 2014 entitled "Sleep Disorders and Associated Medical Comorbidities in Active Duty Military Personnel." That article states that recent evidence suggests the increased incident of sleep disturbances (including sleep apnea) in redeployed military personnel is potentially related to PTSD, depression, anxiety, or TBI. The article cites to a particular study that evaluated polysomnographic data in 69 redeployed soldiers with PTSD, TBI, and other mental health disorders in which a diagnosis of obstructive sleep apnea was made in 76.8% of the participants.

The Board finds that while this article supports a correlation between mental health disorders and sleep apnea (and other sleep disorders), it does *not* support a causal relationship, or, specifically, a finding that psychiatric disorders cause sleep apnea. Indeed, the article states that short sleep duration is also implicated as a potential basis for anxiety and PTSD, indicating that there may be a causal relationship that is the reverse of what this Veteran is claiming (i.e., that sleep apnea causes or aggravates psychiatric disorders). Therefore, the Board does not find the article submitted by the Veteran to be persuasive in considering whether his current sleep apnea is caused or aggravated by his service-connected psychiatric disability.

Based on the evidence of record, the weight of the competent evidence demonstrates no relationship between the Veteran's current sleep apnea and either his military service or his service-connected psychiatric disability, including no credible evidence of recurrent symptoms of sleep apnea during active service, recurrent symptomatology of sleep apnea following service separation, or competent medical evidence establishing a link between the current sleep apnea and either active service or a service-connected disability. Moreover, he has a known, diagnosable condition, does not have patterns of an undiagnosed illness, and has not

been diagnosed with any medically unexplained chronic multisymptom illnesses. Therefore, the Board finds that a preponderance of the lay and medical evidence that is of record weighs against the claim for service connection for sleep apnea, and outweighs the Veteran's more recent contentions regarding in-service recurrent symptoms and recurrent post-service symptoms.

For these reasons, the claim must be denied. Because the preponderance of the evidence is against the claim, the benefit of the doubt doctrine is not for application. *See* 38 U.S.C.A. § 5107; 38 C.F.R. § 3.102.

Service Connection for Hypertension

Next, the Veteran contends that his current hypertension was caused or aggravated by his service-connected psychiatric disability.

He has not contended that his hypertension began during active service. Moreover, his service treatment records are negative for any complaints, symptoms, findings, treatment, or diagnoses of hypertension, and the evidence does not demonstrate a diagnosis of hypertension either during active service or within one year of separation. Indeed, the first diagnosis of hypertension was in July 1999, when private treatment records reveal that the Veteran was diagnosed with borderline hypertension with normal repeat blood pressure readings.

Therefore, because the Veteran has not claimed direct service connection and the evidence does not otherwise suggest a connection between an event or injury during active service and the current hypertension, the Board will focus on the question of whether the hypertension was caused or aggravated by a service-connected disability.

As noted above, to prevail on the issue of secondary service causation, the record must show (1) evidence of a current disability, (2) evidence of a service-connected

disability, and (3) medical nexus evidence establishing a connection between the current disability and the service-connected disability. *Wallin*, 11 Vet. App. at 512; *Reiber*, 7 Vet. App. at 16-17.

First, service connection has been granted for the following disabilities: depressive disorder NOS, gastroesophageal reflux disease (GERD), and plantar hyperkeratosis.

However, the Board finds that the weight of the evidence demonstrates no relationship between the Veteran's hypertension and any of his service-connected disabilities, including depressive disorder.

There are two negative VA opinions of record. The Veteran was afforded a VA examination in August 2009. The VA examiner opined that hypertension was not caused by either military service or by any conditions caused by military service. Next, in April 2013, a VA examiner opined that is it less likely as not that the Veteran's hypertension is proximately due to or the result of his depressive disorder, citing to review of medical literature which supported the opinion.

Moreover, there are no favorable medical opinions of record, nor does the medical evidence otherwise suggest a relationship between the Veteran's hypertension and his service-connected disabilities.

Regarding the Veteran's statements as to the cause of his hypertension, the Board recognizes, as above, that lay witnesses may, in some circumstances, opine on questions of diagnosis and etiology. *See Davidson*, 581 F.3d at 1316 (Board's categorical statement that "a valid medical opinion" was required to establish nexus, and that a layperson was "not competent" to provide testimony as to nexus because she was a layperson, conflicts with *Jandreau*, 492 F.3d 1372). However, in this case, the cause of the Veteran's hypertension involves a complex medical etiological question because it deals with the origin and progression of the Veteran's cardiovascular system, and disorder of such internal and complex disease process is diagnosed primarily on clinical findings and physiological testing. The Veteran is competent to relate symptoms of hypertension that he experienced at any time, but is not competent to opine on whether there is a link between any currently

diagnosed hypertension and a service-connected disability, because such diagnosis requires specific medical knowledge and training. *See Rucker*, 10 Vet. App. at 74 (stating that a lay person is not competent to diagnose or make a competent nexus opinion about a disorder as complex as cancer). For these reasons, the Board finds that weight of the lay and medical evidence that is of record outweighs the Veteran's more recent contentions regarding the relationship between his hypertension and his service-connected psychiatric disability.

Based on the foregoing, the Board finds that the weight of the evidence is against a finding that the Veteran's hypertension was caused or aggravated by any service-connected disability.

For these reasons, service connection for hypertension must be denied. As the preponderance of the evidence weighs against the Veteran's claim for service connection for hypertension, the benefit of the doubt doctrine is not applicable, and the claim for service connection must be denied. *See* 38 U.S.C.A. § 5107(b); 38 C.F.R. § 3.102.

Disability Rating Laws and Regulations

Disability evaluations (ratings) are determined by evaluating the extent to which a veteran's service-connected disability adversely affects his ability to function under the ordinary conditions of daily life, including employment, by comparing the symptomatology with the criteria set forth in the Schedule for Rating Disabilities (Rating Schedule). 38 U.S.C.A. § 1155; 38 C.F.R. §§ 4.1, 4.2, 4.10.

In evaluating a disability, the Board considers the current examination reports in light of the whole recorded history to ensure that the current rating accurately reflects the severity of the condition. The Board has a duty to acknowledge and consider all regulations that are potentially applicable. *Schafrath v. Derwinski*, 1 Vet. App. 589 (1991). The medical as well as industrial history is to be considered, and a full description of the effects of the disability upon ordinary activity is also required. 38 C.F.R. §§ 4.1, 4.2, 4.10.

Where there is a question as to which of two evaluations shall be applied, the higher evaluation will be assigned if the disability picture more nearly approximates the criteria required for that rating. Otherwise, the lower rating will be assigned. *See* 38 C.F.R. § 4.7. Reasonable doubt regarding the degree of disability will be resolved in the veteran's favor. 38 C.F.R. § 4.3.

In view of the number of atypical instances it is not expected, especially with the more fully described grades of disabilities, that all cases will show all the findings specified. Findings sufficiently characteristic to identify the disease and the disability therefrom, and above all, coordination of rating with impairment of function will, however, be expected in all instances. 38 C.F.R. § 4.21 (2015). At the time of an initial rating, separate ratings can be assigned for separate periods of time based on facts found, a practice known as "staged" ratings. *Fenderson v. West*, 12 Vet. App. 119, 126 (1999).

As above, in rendering a decision on appeal, the Board must analyze the credibility and probative value of the evidence, account for the evidence which it finds to be persuasive or unpersuasive, and provide the reasons for its rejection of any material evidence favorable to the claimant. *See Gabrielson*, 7 Vet. App. at 39-40; *Gilbert*, 1 Vet. App. at 57. Competency of evidence differs from weight and credibility. Competency is a legal concept determining whether testimony may be heard and considered by the trier of fact, while credibility is a factual determination going to the probative value of the evidence to be made after the evidence has been admitted. *Rucker*, 10 Vet. App. at 74; *Layno*, 6 Vet. App. at 469; *see also Cartright*, 2 Vet. App. at 25 ("although interest may affect the credibility of testimony, it does not affect competency to testify"). Lay testimony is competent when it regards the readily observable features or symptoms of injury or illness and "may provide sufficient support for a claim of service connection." *See Layno*; 38 C.F.R. § 3.159(a)(2).

Generally, the degree of probative value which may be attributed to a medical opinion issued by a VA or private treatment provider takes into account such factors as its thoroughness and degree of detail, and whether there was review of a veteran's claims file. *See Prejean*, 13 Vet. App. at 448-9. Also significant is

whether the examining medical provider had a sufficiently clear and well-reasoned rationale, as well as a basis in objective supporting clinical data. *See Bloom*, 12 Vet. App. at 187; *Hernandez-Toyens*, 11 Vet. App. at 382; *see also Claiborne*, 19 Vet. App. at 186 (rejecting medical opinions that did not indicate whether the physicians actually examined the veteran, did not provide the extent of any examination, and did not provide any supporting clinical data). The Court has held that a bare conclusion, even one reached by a health care professional, is not probative without a factual predicate in the record. *Miller*, 11 Vet. App. at 348.

A significant factor to be considered for any opinion is the accuracy of the factual predicate, regardless of whether the information supporting the opinion is obtained by review of medical records or lay reports of injury, symptoms and/or treatment. *See Harris*, 203 F.3d at 1350-51 (examiner opinion based on accurate lay history deemed competent medical evidence in support of the claim); *Kowalski*, 19 Vet. App. at 177 (holding that a medical opinion cannot be disregarded solely on the rationale that the medical opinion was based on history given by the veteran); *Reonal*, 5 Vet. App. at 461 (holding that the Board may reject a medical opinion based on an inaccurate factual basis).

Also as above, when all the evidence is assembled, VA is responsible for determining whether the evidence supports the claim or is in relative equipoise, with a veteran prevailing in either event, or whether a preponderance of the evidence is against a claim, in which case, the claim is denied. 38 U.S.C.A. § 5107(b); 38 C.F.R. § 3.102.

The Board has reviewed all the evidence in the Veteran's claims file. Although the Board has an obligation to provide adequate reasons and bases supporting this decision, there is no requirement that the evidence submitted by a veteran or obtained on his behalf be discussed in detail. Rather, the Board's analysis below will focus specifically on what evidence is needed to substantiate the claim and what the evidence in the claims file shows, or fails to show, with respect to the claim. *See Gonzales*, 218 F.3d at 1380-81; *Timberlake*, 14 Vet. App. at 128-30.

Higher Initial Disability Rating for Depressive Disorder

In the February 2009 rating decision on appeal, the RO granted service connection for depressive disorder and assigned an initial 30 percent disability rating, effective from July 18, 2008, the date the Veteran's claim for service connection was received. During the course of this appeal, in a February 2013 rating decision, the RO granted a higher initial disability rating of 50 percent for depressive disorder, effective from July 18, 2008.

The Veteran asserts that his psychiatric symptoms, which include near-continuous depression, irritability, anxiety, panic attacks, ritualistic behavior, and intermittent suicidal ideation, warrant at least a 70 percent disability rating.

Evaluations for depressive disorder are assigned pursuant to 38 C.F.R. § 4.130, DC 9434. A 50 percent rating is assigned where there is occupational and social impairment with reduced reliability and productivity due to such symptoms as: flattened affect; circumstantial, circumlocutory, or stereotyped speech; panic attacks more than once a week; difficulty in understanding complex commands; impairment of short- and long-term memory (e.g., retention of only highly learned material, forgetting to complete tasks); impaired judgment; impaired abstract thinking; disturbances of motivation and mood; and difficulty in establishing and maintaining effective work and social relationships.

A 70 percent rating is assigned where there is occupational and social impairment, with deficiencies in most areas, such as work, school, family relations, judgment, thinking or mood, due to such symptoms as: suicidal ideation; obsessional rituals which interfere with routine activities; speech intermittently illogical, obscure, or irrelevant; near-continuous panic or depression affecting the ability to function independently, appropriately and effectively; impaired impulse control (such as unprovoked irritability with periods of violence); spatial disorientation; neglect of personal appearance and hygiene; difficulty in adapting to stressful circumstances (including work or a work-like setting); and inability to establish and maintain effective relationships.

A 100 percent rating contemplates total occupational and social impairment, due to such symptoms as: gross impairment in thought processes or communication; persistent delusions or hallucinations; grossly inappropriate behavior; persistent danger of hurting self or others; intermittent inability to perform activities of daily living (including maintenance of minimal personal hygiene); disorientation to time or place; memory loss for names of close relatives, own occupation, or own name.

In assessing the evidence of record, the Global Assessment of Functioning (GAF) score is a scale reflecting the "psychological, social, and occupational functioning on a hypothetical continuum of mental health-illness." *Richard v. Brown*, 9 Vet. App. 266, 267 (1996) (citing DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, 4th ed. (DSM-IV) at 32).

A GAF score in the range of 41 to 50 represents "Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job)." *Id.*

A GAF score in the range of 51 to 60 indicates "Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers)." *Id.*

A GAF score in the range of 61 to 70 reflects "Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships." *Id.*

The list of symptoms under the rating criteria are meant to be examples of symptoms that would warrant the evaluation, but are not meant to be exhaustive. The Board need not find all or even some of the symptoms to award a specific evaluation. *Mauerhan v. Principi*, 16 Vet. App. 436, 442-3 (2002). On the other hand, if the evidence shows that a veteran suffers symptoms or effects that cause

occupational or social impairment equivalent to what would be caused by the symptoms listed in the diagnostic code, the appropriate equivalent rating will be assigned. *Mauerhan*, 16 Vet. App. at 443; *Sellers v. Principi*, 372 F.3d 1318, 1326 (Fed. Cir. 2004).

After reviewing all the lay and medical evidence of record and resolving reasonable doubt in favor of the Veteran, the Board finds that the evidence supports a 70 percent disability rating, but no higher, for the entire initial rating period on appeal.

Specifically, throughout the initial rating period on appeal, the Veteran's psychiatric disability was manifested by occupational and social impairment with deficiencies in most areas due to symptoms such as near-continuous depression, irritability, anxiety, panic attacks, ritualistic behavior, and intermittent suicidal ideation, which more nearly approximates the criteria for a 70 percent rating.

The evidence relevant to the initial rating period on appeal demonstrates symptoms of near-continuous depression and irritability, which have a significant impact on the Veteran's social functioning and contribute to his isolation and withdrawal. For example, a July 2008 VA treatment note indicates a gradual increase in symptoms of depression, irritability, anxiety, and withdrawal over the previous several years. The Veteran reported that he had lost his sense of humor, was "snappy" with others, serious, and angry but not aggressive with other people. He further stated that avoided crowds of strangers.

In August 2008, he reported that he was isolative and went out of his way to avoid neighbors. Moreover, he stated he was irritable and had unpredictable outbursts of anger. He said that he had a difficult relationship with his children and, while he had a few friends, he did not have a close relationship with them.

In a November 2008 statement, the Veteran's wife stated that the Veteran would not even take the trash out if the neighbors were outside, and refused to answer the telephone or the door. During a February 2012 psychiatric evaluation performed by a private psychiatrist, the Veteran stated that he did not interact with his children, and often just "lays around" and does not feel like doing anything. The psychiatrist

observed a strong undercurrent of anger and a sullen negativity during his interview of the Veteran.

The evidence also demonstrates that the Veteran's anger and irritability affected him occupationally. For many years, he worked for his step-father at a moving company, and currently works on a part-time basis for the post office. In a January 2009 statement, the Veteran stated he experienced a lot of problems at work due to his psychiatric symptoms with his supervisors, coworkers, and customers. Moreover, he stated that if his step-father were not his boss, he felt he would have been fired a long time ago. VA treatment notes, particularly from 2013, describe conflict with supervisors due to the Veteran's irritability.

In addition to the above symptoms of depression and irritability, throughout the rating period on appeal, the evidence demonstrates severe anxiety, panic attacks, ritualistic behavior, and intermittent suicidal ideation. For instance, in her November 2008 statement, the Veteran's wife states that the Veteran constantly checks to make sure that their doors are locked and wakes at any noise during the night with the belief that someone is breaking in. Moreover, in July 2008, the Veteran sought treatment for anxiety after verbalizing suicidal intent. In August 2013, the Veteran endorsed experiencing panic attacks two times per month, although he had previously stated that panic attacks occurred as often as daily.

Moreover, the Board notes that GAF scores assigned during the rating period on appeal are mostly commensurate with a higher 70 percent disability rating. Namely, he was assigned a GAF score of 50 at the VA Medical Center in September 2008 and at the February 2012 psychiatric evaluation. As noted above, a GAF score of 50 indicates serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting), or any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).

The Board acknowledges that the VA examiners assigned higher GAF scores of 70 and 55 in January 2009 and February 2013, respectively. However, the Board finds that the GAF score of 70 does not accurately reflect the severity of the Veteran's symptoms as described in his treatment notes and even in the January 2009 VA

examination. A GAF score of 70 reflects mild symptoms, but the 2009 VA examination report describes depression on a daily basis and no friends. Moreover, the GAF score of 55, which reflects moderate symptoms, has some overlap with the symptomatology associated with a 70 percent rating.

In sum, the Board finds that the evidence relevant to the entire initial rating period on appeal is at least in equipoise as to whether the Veteran's psychiatric disability causes occupational and social impairment with deficiencies in most areas. In this regard, the Board in particular notes the symptoms of near-continuous depression and irritability, which have contributed to his social isolation and conflict with supervisors, as well as his anxiety, panic attacks, ritualistic behavior, and intermittent suicidal ideation.

In addition, as noted above, the GAF scores reflect moderate to serious symptoms, which are commensurate with a 70 percent disability rating. In this case, the level of social and occupational impairment reflected by the GAF score of 50 is supported by the evidence, which demonstrates that the Veteran is socially isolated, has frequent conflict with supervisors, and experiences frequent anxiety and panic attacks. Such symptoms are commensurate with a higher 70 percent rating.

In sum, the evidence is at least in equipoise as to whether there is occupational and social impairment with deficiencies in most areas, which more nearly approximates a higher 70 percent disability rating, for the entire initial rating period on appeal.

The Board finds that the weight of the evidence is against the assignment of an even higher 100 percent disability rating for any part of the initial rating period on appeal because the evidence does not demonstrate total occupational and social impairment. Treatment notes consistently indicate that the Veteran's judgment and thinking are intact. Moreover, although the Veteran reported social isolation and difficulty getting along with others, he has consistently stated that he has a good relationship with his wife, and, moreover, he still works on a part-time basis. Further, no symptoms commensurate with the criteria for a 100 percent rating category were present during any part of the initial rating period on appeal.

Higher Initial Disability Rating for Plantar Hyperkeratosis

Service connection for plantar hyperkeratosis and psoriasis of the feet was granted in a February 2013 rating decision. A noncompensable, or zero percent, disability rating was assigned under DC 7899-7824, effective from July 18, 2008, the date the Veteran's claim for service connection was received.

Initially, the Board notes that the criteria for rating disabilities of the skin were revised since VA received the Veteran's claim of entitlement to service connection in July 2008.

When the rating criteria are revised during the course of a claim and appeal, VA must determine the rating to be assigned, taking into consideration both the revised and unrevised criteria and assigning the rating based on the criteria most favorable to the claimant, keeping in mind that the revised criteria may not be applied to any time period before the effective date of the change unless retroactive application has been specifically authorized. *See Kuzma v. Principi*, 341 F.3d 1327 (Fed. Cir. 2003).

However, in this case, the rating criteria under which the Veteran's skin disability was evaluated (DC 7824) remained unchanged by the 2008 regulatory revisions. 38 C.F.R. § 4.118 (2015).

In this regard, as noted above, the Veteran's skin disability has been rated by analogy under DC 7899-7824. When an unlisted condition is encountered, it will be permissible to rate under a closely related disease or injury in which not only the functions affected, but the anatomical localization and symptomatology are closely analogous. 38 C.F.R. § 4.20 (2015). According to the policy in the Rating Schedule, when a disability is not specifically listed, the Diagnostic Code will be "built up," meaning that the first two digits will be selected from that part of the schedule most closely identifying the part of the body involved, and the last two digits will be "99." 38 C.F.R. § 4.27 (2015). The hyphenated DC 7899-7824 references an unlisted skin condition comparable to diseases of keratinization. 38 C.F.R. §§ 4.20, 4.21 (2015).

Under 38 C.F.R. § 4.118, DC 7824 provides a noncompensable rating for keratinization if it requires no more than topical therapy during the past twelve-month period. A 10 percent rating is warranted for localized or episodic cutaneous involvement and intermittent systemic medication, such as immunosuppressive retinoids, for a total duration of less than six weeks during the past twelve-month period. A 30 percent rating requires either generalized cutaneous involvement or systemic manifestations, and; intermittent systemic medication, such as immunosuppressive retinoids, for a total duration of six weeks or more, but not constantly, during the past twelve-month period. A 60 percent rating requires a showing of either generalized cutaneous involvement or systemic manifestations, and; constant or near-constant systemic medication, such as immunosuppressive retinoids, during the past twelve-month period. *Id.*

Also potentially relevant is DC 7816, which contemplates psoriasis. Under DC 7816, a noncompensable rating is warranted if less than 5 percent of the entire body or exposed areas are affected and no more than topical therapy was required during the past 12-month period. A 10 percent rating is warranted if at least 5 percent, but less than 20 percent, of the entire body is affected; at least 5 percent, but less than 20 percent, of exposed areas are affected; or intermittent systemic therapy such as corticosteroids or other immunosuppressive drugs were required for a total duration of less than six weeks during the past 12-month period. A 30 percent rating is warranted if 20 to 40 percent of the entire body or 20 to 40 percent of exposed areas are affected; or, systemic therapy such as corticosteroids or other immunosuppressive drugs were required for a total duration of six weeks or more, but not constantly, during the past 12-month period. If more than 40 percent of the entire body or more than 40 percent of exposed areas are affected; or, constant or near-constant systemic therapy such as corticosteroids or other immunosuppressive drugs were required during the past 12-month period, a 60 percent rating is warranted. 38 C.F.R. § 4.118.

Based on a review of the evidence, lay and medical, the Board finds that the preponderance of the evidence is against the assignment of a compensable disability rating for plantar hyperkeratosis for the entire initial rating period on appeal, as

there is no evidence that systemic medication/therapy was required for any period, and less than five percent of the total body and exposed areas were affected.

VA treatment notes from August 2008 show that the Veteran was diagnosed with "cracked feet" and was told to apply Eucerin lotion. In October 2008, the VA clinician noted that the Veteran's dry skin of the feet was "doing fine," and that he would prescribe Lidex cream as needed.

The Veteran was afforded a VA examination in January 2009. Physical examination revealed mildly dry skin and callus formation of the bilateral heels, with no cracking of the dry skin of either heel. There was also a five by three centimeter oval area of dry, slightly thickened, non-scaling skin at the anterior aspect of the left lateral malleolus, and an area of dry mildly scaly, non-cracked skin of the pads of the first through fifth toes, their web spaces, and the soles over the adjacent metatarsal heads. There was no purulent drainage or evidence of inflammation. The area of the dry skin represented zero percent of total body area exposed. The examiner noted that the Veteran had been prescribed various topical ointments.

The Veteran was afforded another VA examination in February 2013. The VA examiner noted that he had been treated with over-the-counter lotions and powders constantly or near-constantly. He had not experienced any debilitating episodes due to the skin disability. Physical examination revealed hyperkeratotic heels, right greater than left, and of the plantar aspect of the right forefoot. The VA examiner assessed that less than five percent of the total body and zero percent of exposed areas were affected. Moreover, the examiner noted that the skin disability did not affect the Veteran's ability to work.

Based on the foregoing and the lay evidence of record, the Board finds that the preponderance of the evidence is against a compensable disability rating for the entire initial rating period on appeal. Namely, the evidence does not demonstrate that systemic medication has been required at any time.

The Board has considered whether any other diagnostic codes would allow for a higher disability rating. DC 7824 is the most applicable diagnostic code. As noted above, DC 7816 is also potentially applicable. However, as noted above, less than five percent of the total body and exposed areas are affected by the skin disability, and no more than topical therapy has been required at all times; therefore, a compensable disability rating is not warranted under DC 7816.

For these reasons, the Board finds that the weight of the evidence is against a finding of a compensable disability rating for plantar hyperkeratosis and psoriasis of the feet for any period. To the extent any higher level of compensation is sought, the preponderance of the evidence is against this claim, and, hence, the benefit-of-the-doubt doctrine does not apply. 38 U.S.C.A. § 5107(b); 38 C.F.R. §§ 4.3, 4.7.

Extraschedular Consideration

The Board has considered whether an extraschedular evaluation is warranted for the Veteran's depressive disorder and plantar hyperkeratosis and psoriasis of the feet. In exceptional cases an extraschedular rating may be provided. 38 C.F.R. § 3.321 (2015). The threshold factor for extraschedular consideration is a finding that the evidence before VA presents such an exceptional disability picture that the available schedular evaluations for that service-connected disability are inadequate. Therefore, initially, there must be a comparison between the level of severity and symptomatology of the claimant's service-connected disability with the established criteria found in the rating schedule for that disability. *Thun v. Peake*, 22 Vet. App. 111 (2008).

Under the approach prescribed by VA, if the criteria reasonably describe the claimant's disability level and symptomatology, then the claimant's disability picture is contemplated by the rating schedule, the assigned schedular evaluation is, therefore, adequate, and no referral is required. In the second step of the inquiry, however, if the schedular evaluation does not contemplate the claimant's level of disability and symptomatology and is found inadequate, the RO or Board must determine whether the claimant's exceptional disability picture exhibits other related factors such as those provided by the regulation as "governing norms." 38 C.F.R. 3.321(b)(1) (related factors include "marked interference with employment"

and "frequent periods of hospitalization"). When the rating schedule is inadequate to evaluate a claimant's disability picture and that picture has related factors such as marked interference with employment or frequent periods of hospitalization, then the case must be referred to the Under Secretary for Benefits or the Director of the Compensation and Pension Service for completion of the third step-a determination of whether, to accord justice, the claimant's disability picture requires the assignment of an extraschedular rating. *Id.*

Turning to the first step of the extraschedular analysis, the Board finds that the symptomatology and impairments caused by the Veteran's service-connected disabilities are specifically contemplated by or are "like or similar to" those explicitly listed in the schedular rating criteria (as discussed in detail above), and no referral for extraschedular consideration is required. *Mauerhan*, 16 Vet. App. at 443.

The Veteran has not expressly raised the matter of entitlement to an extraschedular rating. His contentions have been limited to those discussed above, i.e., that his depressive disorder and plantar hyperkeratosis are more severe than is reflected by the assigned ratings. As was explained in the merits decision above in denying higher ratings, the criteria for higher schedular ratings were considered, but the ratings assigned were upheld (except as otherwise indicated) because the rating criteria are adequate. In view of the circumstances, the Board finds that the rating schedule is adequate, even in regard to the collective and combined effect of all of the Veteran's service-connected disabilities, and that referral for extraschedular consideration is not warranted under the circumstances of this case. *Johnson v. McDonald*, 762 F.3d 1362 (Fed. Cir. 2014).

Beyond the above, the Board has considered the issue of whether unemployability (TDIU) has been raised by the record. In this regard, the Board must note no indication that the issue of TDIU has been raised by this record. Although the Veteran has noted problems with his service-connected disabilities, including some resulting occupational difficulties, he continues to work and has not indicated he is unable to work due to his service-connected disabilities (nor does the evidence of record suggest this).

Duties to Notify and Assist

The Veterans Claims Assistance Act of 2000 (VCAA) and implementing regulations impose obligations on VA to provide claimants with notice and assistance. 38 U.S.C.A. §§ 5102, 5103, 5103A, 5107, 5126 (West 2014); 38 C.F.R. §§ 3.102, 3.156(a), 3.159, 3.326(a) (2015).

Because the current appeal as to the psychiatric and skin disability ratings arises from the Veteran's disagreement with the initial evaluations following the grant of service connection for the psychiatric and skin disabilities, no additional notice is required. The United States Court of Appeals for the Federal Circuit (Federal Circuit) and the Court have held that, once service connection is granted and the claim is substantiated, additional notice is not required, and any defect in notice is not prejudicial. *Hartman v. Nicholson*, 483 F.3d 1311 (Fed. Cir. 2007); *Dunlap v. Nicholson*, 21 Vet. App.112 (2007); 38 C.F.R. § 3.159(b)(3)(i) (no duty to provide VCAA notice upon receipt of a notice of disagreement); VAOPGCPREC 8-2003 (in which the VA General Counsel interpreted that separate notification is not required for "downstream" issues following a service connection grant, such as initial rating and effective date claims).

With regard to the remainder of the claims decided herein, the duty to notify was satisfied by way of August 2008 and May 2011 letters to the Veteran.

The Board is also satisfied VA has made reasonable efforts to obtain relevant records and evidence. Specifically, the information and evidence that has been associated with the claims file includes the Veteran's service treatment records, service personnel records, post-service VA and private treatment records, VA examinations and opinions, and the Veteran's statements.

VA examinations and opinions were obtained in August 2009 and April 2013 with regard to the sleep apnea and hypertension claims. To that end, when VA undertakes to provide a VA examination or obtain a VA opinion, it must ensure that the examination or opinion is adequate. *Barr v. Nicholson*, 21 Vet. App. 303, 312

(2007). The Board finds that the VA examinations and opinions obtained in this case are adequate. The opinions were predicated on a full reading of the private and VA medical records in the Veteran's claims file, as well as an interview and physical examination of the Veteran. The VA nexus opinions considered all of the pertinent evidence of record, to include VA treatment records, comprehensive physical examinations, and the statements of the Veteran, and provide complete rationale for the opinions stated, relying on and citing to the records reviewed. Accordingly, the Board finds that VA's duty to assist with respect to obtaining a VA examination or opinion with respect to the sleep apnea and hypertension claims has been met. 38 C.F.R. § 3.159(c)(4).

To the extent that VA examinations were obtained with regard to the hearing loss, tinnitus, and headache claims, the Board need not address the adequacy of those examinations and opinions. In the context of claims to reopen, the duty to provide an examination or obtain an opinion is a "conditional or provisional duty." *Woehlaert v. Nicholson*, 21 Vet. App. 456, 463 (2007); *see also* 38 C.F.R. § 3.159(c). In this case, the Board has determined that new and material evidence has not been received to reopen the claims of entitlement to service connection for the above disorders. Thus, VA's duty to provide an examination or obtain an opinion with regard to the hearing loss, tinnitus, and headache claims is extinguished. *Woehlaert*, 21 Vet. App. at 463.

The Veteran has been afforded an adequate examination on the issue of rating the service-connected depressive disorder and skin disability. VA provided the Veteran with examinations in January 2009, November 2011, and February 2013. The Veteran's history was taken, and complete examinations were conducted. Conclusions reached and diagnoses given were consistent with the examination reports. Therefore, the Veteran has been afforded adequate examinations on the initial disability rating issues decided herein. *Nieves-Rodriguez v. Peake*, 22 Vet. App. 295 (2008).

Notably, the Veteran has not identified, and the record does not otherwise indicate, any additional existing evidence that is necessary for a fair adjudication of the claim that has not been obtained. Hence, no further notice or assistance to the Veteran is

required to fulfill VA's duty to assist in the development of the claim. *Smith v. Gober*, 14 Vet. App. 227 (2000), *aff'd* 281 F.3d 1384 (Fed. Cir. 2002); *Dela Cruz v. Principi*, 15 Vet. App. 143 (2001); *see also Quartuccio v. Principi*, 16 Vet. App. 183 (2002).

ORDER

The claim of entitlement to service connection for PTSD is dismissed.

New and material evidence having been received, the claim of entitlement to service connection for a medically unexplained chronic multisymptom illness manifested by pain and numbness of the bilateral upper extremities as a result of exposure to environmental hazards during Gulf War service, claimed as nerve damage, is reopened and granted.

New and material evidence having been received, the claim of entitlement to service connection for a medically unexplained chronic multisymptom illness manifested by pain and numbness of the bilateral lower extremities as a result of exposure to environmental hazards during Gulf War service, claimed as nerve damage, is reopened and granted.

New and material evidence having been received, the claim of entitlement to service connection for sleep apnea is reopened.

New and material evidence not having been received, the appeal to reopen the claim of entitlement to service connection for bilateral hearing loss is denied.

New and material evidence not having been received, the appeal to reopen the claim of entitlement to service connection for tinnitus is denied.

New and material evidence not having been received, the appeal to reopen the claim of entitlement to service connection for headaches is denied.

IN THE APPEAL OF [redacted]
JOSEPH HARVEY

Service connection for sleep apnea is denied.

Service connection for hypertension is denied.

A 70 percent disability rating for service-connected depressive disorder, but no higher, is granted for the entire initial rating period on appeal.

An initial compensable disability rating for plantar hyperkeratosis and psoriasis of the feet is denied.

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JONATHAN B. KRAMER
Veterans Law Judge, Board of Veterans' Appeals

Department of Veterans Affairs

YOUR RIGHTS TO APPEAL OUR DECISION

The attached decision by the Board of Veterans' Appeals (BVA or Board) is the final decision for all issues addressed in the "Order" section of the decision. The Board may also choose to remand an issue or issues to the local VA office for additional development. If the Board did this in your case, then a "Remand" section follows the "Order." However, you cannot appeal an issue remanded to the local VA office because a remand is not a final decision. *The advice below on how to appeal a claim applies only to issues that were allowed, denied, or dismissed in the "Order."*

If you are satisfied with the outcome of your appeal, you do not need to do anything. We will return your file to your local VA office to implement the BVA's decision. However, if you are not satisfied with the Board's decision on any or all of the issues allowed, denied, or dismissed, you have the following options, which are listed in no particular order of importance:

- Appeal to the United States Court of Appeals for Veterans Claims (Court)
- File with the Board a motion for reconsideration of this decision
- File with the Board a motion to vacate this decision
- File with the Board a motion for revision of this decision based on clear and unmistakable error.

Although it would not affect this BVA decision, you may choose to also:

- Reopen your claim at the local VA office by submitting new and material evidence.

There is *no* time limit for filing a motion for reconsideration, a motion to vacate, or a motion for revision based on clear and unmistakable error with the Board, or a claim to reopen at the local VA office. None of these things is mutually exclusive - you can do all five things at the same time if you wish. However, if you file a Notice of Appeal with the Court and a motion with the Board at the same time, this may delay your case because of jurisdictional conflicts. If you file a Notice of Appeal with the Court ***before*** you file a motion with the BVA, the BVA will not be able to consider your motion without the Court's permission.

How long do I have to start my appeal to the court? You have **120 days** from the date this decision was mailed to you (as shown on the first page of this decision) to file a Notice of Appeal with the Court. If you also want to file a motion for reconsideration or a motion to vacate, you will still have time to appeal to the court. *As long as you file your motion(s) with the Board within 120 days of the date this decision was mailed to you,* you will have another 120 days from the date the BVA decides the motion for reconsideration or the motion to vacate to appeal to the Court. You should know that even if you have a representative, as discussed below, *it is your responsibility to make sure that your appeal to the Court is filed on time*. Please note that the 120-day time limit to file a Notice of Appeal with the Court does not include a period of active duty. If your active military service materially affects your ability to file a Notice of Appeal (e.g., due to a combat deployment), you may also be entitled to an additional 90 days after active duty service terminates before the 120-day appeal period (or remainder of the appeal period) begins to run.

How do I appeal to the United States Court of Appeals for Veterans Claims? Send your Notice of Appeal to the Court at:

Clerk, U.S. Court of Appeals for Veterans Claims
625 Indiana Avenue, NW, Suite 900
Washington, DC 20004-2950

You can get information about the Notice of Appeal, the procedure for filing a Notice of Appeal, the filing fee (or a motion to waive the filing fee if payment would cause financial hardship), and other matters covered by the Court's rules directly from the Court. You can also get this information from the Court's website on the Internet at: http://www.uscourts.cavc.gov, and you can download forms directly from that website. The Court's facsimile number is (202) 501-5848.

To ensure full protection of your right of appeal to the Court, you must file your Notice of Appeal **with the Court**, not with the Board, or any other VA office.

How do I file a motion for reconsideration? You can file a motion asking the BVA to reconsider any part of this decision by writing a letter to the BVA clearly explaining why you believe that the BVA committed an obvious error of fact or law, or stating that new and material military service records have been discovered that apply to your appeal. It is important that such letter be as specific as possible. A general statement of dissatisfaction with the BVA decision or some other aspect of the VA claims adjudication process will not suffice. If the BVA has decided more than one issue, be sure to tell us which issue(s) you want reconsidered. Issues not clearly identified will not be considered. Send your letter to:

Director, Management, Planning and Analysis (014)
Board of Veterans' Appeals
810 Vermont Avenue, NW
Washington, DC 20420

Remember, the Board places no time limit on filing a motion for reconsideration, and you can do this at any time. However, if you also plan to appeal this decision to the Court, you must file your motion within 120 days from the date of this decision.

How do I file a motion to vacate? You can file a motion asking the BVA to vacate any part of this decision by writing a letter to the BVA stating why you believe you were denied due process of law during your appeal. *See* 38 C.F.R. 20.904. For example, you were denied your right to representation through action or inaction by VA personnel, you were not provided a Statement of the Case or Supplemental Statement of the Case, or you did not get a personal hearing that you requested. You can also file a motion to vacate any part of this decision on the basis that the Board allowed benefits based on false or fraudulent evidence. Send this motion to the address above for the Director, Management, Planning and Analysis, at the Board. Remember, the Board places no time limit on filing a motion to vacate, and you can do this at any time. However, if you also plan to appeal this decision to the Court, you must file your motion within 120 days from the date of this decision.

How do I file a motion to revise the Board's decision on the basis of clear and unmistakable error? You can file a motion asking that the Board revise this decision if you believe that the decision is based on "clear and unmistakable error" (CUE). Send this motion to the address above for the Director, Management, Planning and Analysis, at the Board. You should be careful when preparing such a motion because it must meet specific requirements, and the Board will not review a final decision on this basis more than once. You should carefully review the Board's Rules of Practice on CUE, 38 C.F.R. 20.1400 -- 20.1411, and *seek help from a qualified representative before filing such a motion.* See discussion on representation below. Remember, the Board places no time limit on filing a CUE review motion, and you can do this at any time.

How do I reopen my claim? You can ask your local VA office to reopen your claim by simply sending them a statement indicating that you want to reopen your claim. However, to be successful in reopening your claim, you must submit new and material evidence to that office. *See* 38 C.F.R. 3.156(a).

Can someone represent me in my appeal? Yes. You can always represent yourself in any claim before VA, including the BVA, but you can also appoint someone to represent you. An accredited representative of a recognized service organization may represent you free of charge. VA approves these organizations to help veterans, service members, and dependents prepare their claims and present them to VA. An accredited representative works for the service organization and knows how to prepare and present claims. You can find a listing of these organizations on the Internet at: http://www.va.gov/vso/. You can also choose to be represented by a private attorney or by an "agent." (An agent is a person who is not a lawyer, but is specially accredited by VA.)

If you want someone to represent you before the Court, rather than before the VA, you can get information on how to do so at the Court's website at: http://www.uscourts.cavc.gov. The Court's website provides a state-by-state listing of persons admitted to practice before the Court who have indicated their availability to the represent appellants. You may also request this information by writing directly to the Court. Information about free representation through the Veterans Consortium Pro Bono Program is also available at the Court's website, or at: http://www.vetsprobono.org, mail@vetsprobono.org, or (855) 446-9678.

Do I have to pay an attorney or agent to represent me? An attorney or agent may charge a fee to represent you after a notice of disagreement has been filed with respect to your case, provided that the notice of disagreement was filed on or after June 20, 2007. *See* 38 U.S.C. 5904; 38 C.F.R. 14.636. If the notice of disagreement was filed before June 20, 2007, an attorney or accredited agent may charge fees for services, but only after the Board first issues a final decision in the case, and only if the agent or attorney is hired within one year of the Board's decision. *See* 38 C.F.R. 14.636(c)(2).

The notice of disagreement limitation does not apply to fees charged, allowed, or paid for services provided with respect to proceedings before a court. VA cannot pay the fees of your attorney or agent, with the exception of payment of fees out of past-due benefits awarded to you on the basis of your claim when provided for in a fee agreement.

Fee for VA home and small business loan cases: An attorney or agent may charge you a reasonable fee for services involving a VA home loan or small business loan. *See* 38 U.S.C. 5904; 38 C.F.R. 14.636(d).

Filing of Fee Agreements: In all cases, a copy of any fee agreement between you and an attorney or accredited agent must be sent to the Secretary at the following address:

Office of the General Counsel (022D)
810 Vermont Avenue, NW
Washington, DC 20420

The Office of General Counsel may decide, on its own, to review a fee agreement or expenses charged by your agent or attorney for reasonableness. You can also file a motion requesting such review to the address above for the Office of General Counsel. *See* 38 C.F.R. 14.636(i); 14.637(d).